COLORADO
Department of Health Care Policy & Financing

Colorado Health Care Affordability Act Annual Report

Hospital Provider Fee Oversight and Advisory Board
January 15, 2016

Colorado Health Care Affordability Act
Annual Report

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Executive Summary

The Department of Health Care Policy and Financing (the Department) and the Hospital Provider Fee Oversight and Advisory Board (OAB) have prepared this annual report concerning the implementation of the Colorado Health Care Affordability Act (CHCAA). The CHCAA authorizes the Department to assess a hospital provider fee to generate additional federal Medicaid matching funds to expand health care access, improve the quality of care for clients serviced by public health insurance programs, increase funding for hospital care for Medicaid and Colorado Indigent Care Program (CICP) clients, and reduce cost-shifting to private payers.

From October 2014 through September 2015, the CHCAA has:

Provided $335 million in increased reimbursement to hospital providers

Commented [DN2]: Continue referring to figure with supplanted CICP funding included?

During the October 2014 through September 2015 time period, hospitals received more than $1.1 billion million in supplemental Medicaid and Disproportionate Share Hospital (DSH) payments financed with hospital provider fees, including $61 million in hospital quality incentive payments. This funding resulted in nearly $335 million in a net reimbursement increase for care provided to Medicaid and CICP clients with no increase in General Fund expenditures.

Reduced uncompensated care costs and the need to shift uncompensated care costs to other payers

The CHCAA reduces uncompensated care for hospital providers and the need to shift those costs to private payers by increasing reimbursement to hospitals for care provided to Medicaid and CICP patients and by reducing the number of uninsured Coloradans. In calendar year 2009, prior to the implementation of the CHCAA, Medicaid reimbursement to Colorado hospitals was approximately 61% of cost. The latest data from calendar year 2014 indicates that Medicaid reimbursement to hospitals has improved to approximately 80% of cost.

Commented [DN3]: Awaiting final cost shift data report

Provided health care coverage through Medicaid and the Child Health Plan *Plus* (CHP+) for more than 400,000 Coloradans

Health coverage expansions in Medicaid and CHP+ funded with hospital provider fees began in 2010, when the population expansions for Medicaid parents and CHP+ children and pregnant women were implemented. In 2012, the Medicaid Buy-In Programs for Working Adults and Children with Disabilities, as well as a limited enrollment for adults without dependent children, were implemented. In 2014, pursuant to Senate Bill 13-200, Medicaid coverage for parents and adults without dependent children was increased up to federal limits and 12-month continuous eligibility for children enrolled in Medicaid were implemented.

As of September 30, 2015, the Department has enrolled approximately 90,000 Medicaid parents, 15,000 CHP+ children and pregnant women, 9,700 adults and children with disabilities, and 289,000 adults without dependent children with no increase in General Fund expenditures.

Colorado Health Care Affordability Act Overview

Commented [DN4]: No changes to this section compared to last year

On April 21, 2009, the Governor signed House Bill 09-1293, the Colorado Health Care Affordability Act (CHCAA) into law. The legislation provides health care coverage to previously uninsured Coloradans, reduces uncompensated care costs, and benefits the state as a whole. These benefits are achieved through an increase in federal funds with no General Fund impact. The Colorado Hospital Association (CHA), the Department of Health Care Policy and Financing (the Department), and the Governor's Office worked together for nearly one year to develop House Bill 09-1293, which passed both the House and the Senate with more than 40 co-sponsors and bipartisan support.

The CHCAA requires the Department to assess and collect a provider fee from all licensed or certified hospital providers, including providers that do not serve Medicaid clients. The provisions of the legislation prohibit shifting the fee to either clients or insurers. By partnering with hospitals, the CHCAA allows Colorado to draw down in federal Medicaid matching funds annually for the following purposes authorized under CHCAA:

- Increase hospital reimbursement payments for Medicaid inpatient and outpatient care, up to a maximum of the federal Upper Payment Limit (UPL);
- Increase hospital reimbursement through the Colorado Indigent Care Program (CICP), up to 100% of cost;
- Create hospital quality incentive payments for rewarding enhanced quality, health outcomes, and cost effectiveness;
- Increase coverage for parents with incomes of up to 133%[1] of the federal poverty level (FPL) through Medicaid;
- Increase coverage in the Child Health Plan *Plus* (CHP+) up to 250% FPL;
- Reduce the number of uninsured Coloradans through implementation of health care coverage for adults without dependent children (AwDC) with incomes of up to 133% FPL[1];
- Create a Medicaid Buy-In Program for individuals with disabilities whose family incomes are too high for Medicaid eligibility but are under 450% FPL;
- Implement continuous eligibility for Medicaid children to reduce administrative burdens on Colorado families and keep eligible kids covered on a continuing basis; and,
- Cover the Department's related administrative costs.

[1] Note: Senate Bill 13-200 increased the coverage for Medicaid parents and AwDC to 133% of the FPL.

Hospital Provider Fee Oversight and Advisory Board

Commented [DN5]: No changes compared to prior year except updated OAB's website URL

A thirteen member Hospital Provider Fee Oversight and Advisory Board (OAB) appointed by the Governor provides oversight and makes recommendations to the Department and the Medical Services Board on the implementation of the CHCAA. See Appendix C for a list of OAB members.

The CHCAA outlines the specific duties of the OAB, including:

- Recommend to the Department the method of calculating the provider fee, the amount of the provider fee, and changes in the provider fee that increase the number of hospitals benefitting from the fee;
- Recommend to the Department changes to Medicaid inpatient and outpatient hospital payments and quality incentive payments to increase hospital accountability, performance, and reporting;
- Recommend to the Department the approach to health coverage expansions;
- Monitor the impact of the hospital provider fee on the broader health care marketplace; and
- As requested, consult with the Health and Human Services Committees (or any successor committees) of the Colorado Senate and House of Representatives.

The OAB's meetings are held regularly from 3:00 p.m. to 5:00 p.m. on the fourth Tuesday of most months (the OAB typically does not meet in January, March, May, or September). Time for public comments is reserved at all meetings and the meetings are streamed over the Internet. All OAB meeting dates, agendas, minutes, and materials discussed at the meetings are posted on the Department's website under Colorado.gov/hcpf/hospital-provider-fee-oversight-and-advisory-board.

Department and Medical Services Board Roles

The Medical Services Board, in consultation with the OAB, is responsible for promulgating rules related to implementing the CHCAA, including the calculation, assessment, and timing of the hospital provider fee; the reports that hospitals will be required to report to the Department; and other rules necessary to implement the CHCAA. Rules regarding the hospital provider fee and payments can be found at 10 CCR 2505-10, Section 8.2000.

The Department administers and provides technical and regulatory expertise to the OAB. Department staff prepares and presents proposed rule changes as recommended by the OAB to the Medical Services Board. The Department is responsible for calculating the fee and assessing the fee on a schedule established in rule by the Medical Services Board. The Department implements and calculates the hospital payments and administers the public health care expansions.

Colorado Health Care Affordability Act Benefits

The CHCAA benefits Colorado by providing additional federal matching funds in the state without additional General Fund expenditure. Fees assessed on hospital providers with federal matching funds allow Colorado to:

- Increase hospital reimbursement for care provided to Medicaid and CICP clients;
- Increase the number of insured Coloradans;
- Improve the quality of health care for Medicaid clients; and
- Reduce the need to shift the cost of uncompensated care to other payers.

Figures in this report are reported on an October 2014 through September 2015 basis unless otherwise noted.

Increase Hospital Reimbursement for Care Provided to Medicaid and CICP Clients

Commented [DN6]: Additional narrative in this section

In the October 2014 through September 2015 period, payments to hospitals financed with hospital provider fees totaled more than $1.1 billion, including $61 million in quality incentive payments.

In prior years, the increased hospital reimbursement for hospitals included 11 to 13 distinct payment calculations and were reported under Inpatient Hospital Reimbursement, Outpatient Hospital Reimbursement, CICP Hospital Reimbursement, Hospital Quality Incentive Payments, and Additional Hospital Payments. For the October 2014 through September 2015 period, the OAB recommended that the payment categories be combined to increase transparency and ease of understanding for stakeholders while ensuring that payments are focused on increasing hospital reimbursement for Medicaid and uninsured persons and incentivizing quality care.

The OAB also recommended payment changes for hospitals that participate in the CICP. Following the expansion of Medicaid eligibility in January 2014, the number of persons in the CICP program declined by approximately 75 percent. In recognition of this shift, the OAB recommended that CICP participating hospitals remain eligible to receive Disproportionate Share Hospital (DSH) payments while all hospitals would be eligible for an uncompensated care payment.

These changes resulted in payments in the five categories reflected in the table below.

2014-15 Hospital Reimbursement	
Inpatient Hospital Reimbursement	$606,802,000
Outpatient Hospital Reimbursement	$207,647,000
Uncompensated Care Payment	$115,400,000
Disproportionate Share Hospital Payment	$194,902,000
Hospital Quality Incentive Payment	$61,449,000
Total Supplemental Hospital Payments	**$1,186,200,000**

Table 1

After taking into account the hospital provider fees collected for health coverage expansions, the Department's administrative expenses, and the CICP hospital reimbursement level prior to increased payments under CHCAA, the net reimbursement increase to hospitals for care provided to Medicaid and uninsured patients and quality incentive payments was more than $334 million for the 2014-15 time period.

2014-15 Net Reimbursement Increase to Hospitals	
Total Supplemental Hospital Payments	$1,186,200,000
Total Fees	($688,448,000)
Approximate CICP payments pre-CHCAA	($162,876,000)
Net Reimbursement Increase to Hospitals	**$334,876,000**

Table 2

See Appendix B for a list of fees, payments, and net reimbursement increases by hospital.

Increase the Number of Insured Coloradans

In May 2010 the population expansions for Medicaid parents to 100% FPL and CHP+ to 250% FPL were implemented. In March 2012, the Medicaid Buy-In Program for Working Adults with Disabilities to 450% FPL was implemented, and in July 2012 the Medicaid Buy-In Program for Children with Disabilities to 300% FPL was implemented. In April 2012, Medicaid coverage for AwDC up to 10% FPL with enrollment capped at 10,000 individuals was implemented. Subsequently, in April 2013, the Department increased the AwDC enrollment cap by 3,000 individuals, then by 1,250 additional individuals each month. On January 1, 2014, pursuant to Senate Bill 13-200, coverage for Medicaid parents and AwDC was increased to 133% FPL and the waitlist for AwDC clients was eliminated. On March 1, 2014, 12-month continuous eligibility for children enrolled in Medicaid was implemented.

The caseload reported as of September 30, 2015 was as follows:

Commented [DN7]: updated

90,107 Medicaid parents,

15,127 CHP+ children and pregnant women,

9,733 working adults and children with disabilities, and

288,998 adults without dependent children.

Improve the Quality of Health Care for Medicaid Clients

Commented [DN8]: has been updated to reflect 2014-15 HQIP

The CHCAA included a provision to establish Hospital Quality Incentive Payments (HQIP) funded by hospital provider fees to improve the quality of care provided in Colorado hospitals.

At the request of the OAB, a HQIP subcommittee was formed to develop a thorough proposal for quality incentive payments. Members of the HQIP subcommittee include representatives from the Department, the CHA, and hospital representatives with expertise in quality measurement and hospital payment. The subcommittee began meeting in January 2011.

The HQIP subcommittee seeks to:

Adopt measures that can be prospectively set to allow time for planning and successful implementation;

Identify measures and methodologies that apply to care provided to Medicaid clients;

Adhere to Value-Based Purchasing (VBP) principles;

Maximize participation in the Medicaid program; and

Minimize the number of hospitals which would not qualify for selected measures.

The HQIP measures are specific to the hospital provider fee program and are not intended to be a full hospital report card.

HQIP: 2014-15 Measures and Payments

The HQIP subcommittee recommended and the OAB approved the following measures for HQIP payments for the year beginning October 1, 2014:

1. Emergency department process
2. Postoperative pulmonary embolism or deep vein thrombosis (PPE/DVT)
3. Elective delivery between 37 and 39 weeks gestation
4. 30 Day all-cause readmissions
5. Cesarean Sections for low-risk, first birth women.

The HQIP payments earned for each of the 2014-15 measures are based on points per Medicaid adjusted discharge. Medicaid adjusted discharges are calculated by dividing the total Medicaid gross charges by Medicaid inpatient service charges and multiplying the result by the total Medicaid discharges.

Points Eligible

The total points eligible for any hospital are the sum of points for each measure for which the hospital qualified.

Points Earned

Total points earned are normalized so hospitals are not negatively impacted by the measures for which they did not meet the minimum criteria. That is, if a hospital scored 21 points, but only qualified for three measures worth a total of 36 points, the total HQIP points earned would be 27: (21/36 = 0.58 x 46 = 27). A maximum award of 10 points was possible for four of the five HQIP measures with 6 points for the emergency department process measure for 46 total possible points.

Payment Calculation

Each hospital's HQIP payment is calculated as:

> Points Earned multiplied by Medicaid Adjusted Discharges multiplied by $20.32 (dollars per adjusted discharge point) equals HQIP Payment.

During the 2014-15 timeframe, HQIP payments totaled more than $61 million with 75 hospitals receiving payments. HQIP payments, eligible points, and earned points by hospital are listed in the following table.

2014-15 Hospital Quality Incentive Payments

Hospital	County	Points Earned	Medicaid Adjusted Discharges	HQIP Payment
Centura Health-St. Anthony North Hospital	Adams	24	2,665	$1,300,000
HealthOne North Suburban Medical Center	Adams	32	3,781	$2,459,000
HealthOne Spalding Rehabilitation Hospital	Adams	14	75	$21,000
Platte Valley Medical Center	Adams	19	1,805	$697,000
The Children's Hospital	Adams	32	9,917	$6,373,000
University of Colorado Hospital	Adams	25	7,039	$3,576,000
San Luis Valley Regional Medical Center	Alamosa	26	1,552	$820,000
Centura Health-Littleton Adventist Hospital	Arapahoe	19	1,375	$531,000
Craig Hospital	Arapahoe	14	64	$18,000
HealthOne Swedish Medical Center	Arapahoe	17	3,189	$1,102,000
HealthOne The Medical Center of Aurora	Arapahoe	27	4,002	$2,196,000
Pagosa Mountain Hospital	Archuleta	16	153	$50,000
Southeast Colorado Hospital & LTC	Baca	26	119	$62,000
Boulder Community Health	Boulder	15	1,083	$330,000
Centura Health-Avista Adventist Hospital	Boulder	21	1,653	$705,000

2014-15 Hospital Quality Incentive Payments				
Hospital	**County**	**Points Earned**	**Medicaid Adjusted Discharges**	**HQIP Payment**
Exempla Good Samaritan	Boulder	22	1,303	$583,000
Longmont United Hospital	Boulder	24	1,843	$899,000
Heart of the Rockies Regional Medical Center	Chaffee	31	444	$280,000
Keefe Memorial Hospital	Cheyenne	17	38	$13,000
Delta County Memorial Hospital	Delta	21	500	$213,000
Centura Health-Porter Adventist Hospital	Denver	16	1,059	$343,000
Centura Health-St. Anthony Central Hospital	Denver	11	1,256	$271,000
Denver Health Medical Center, Hospital	Denver	24	8,338	$4,067,000
Exempla Saint Joseph Hospital, Inc.	Denver	30	3,346	$2,040,000
HealthOne Presbyterian/St. Luke's Medical Center	Denver	20	2,729	$1,109,000
HealthOne Rose Medical Center	Denver	22	2,825	$1,263,000
National Jewish Medical and Research Center	Denver	23	1,912	$894,000
Centura Health-Parker Adventist Hospital	Douglas	22	1,303	$583,000
HealthOne Sky Ridge Medical Center	Douglas	26	1,048	$554,000
Vail Valley Medical Center	Eagle	15	364	$111,000
Centura Health-Penrose-St. Francis Health	El Paso	36	4,566	$3,341,000
Memorial Hospital	El Paso	24	12,657	$6,174,000
Select Specialty Hospital - Colorado Springs	El Paso	46	1	$1,000
Centura Health-St. Thomas More Hospital	Fremont	23	1,041	$487,000
Grand River Medical Center	Garfield	28	394	$227,000
Valley View Hospital	Garfield	31	1,282	$808,000
Gunnison Valley Hospital	Gunnison	21	313	$133,000
Spanish Peaks Regional Health Center	Huerfano	40	283	$231,000
Exempla Lutheran Medical Center	Jefferson	23	4,248	$1,986,000
Weisbrod Memorial County Hospital	Kiowa	29	80	$47,000
Kit Carson County Memorial Hospital	Kit Carson	34	419	$286,000
Animas Surgical Hospital	La Plata	14	231	$67,000
Centura Health-Mercy Regional Medical Center	La Plata	22	991	$443,000
St. Vincent General Hospital District	Lake	6	147	$17,000
Banner Health-McKee Medical Center	Larimer	17	1,743	$602,000
Estes Park Medical Center	Larimer	25	166	$84,000
Medical Center of the Rockies	Larimer	18	918	$336,000
Poudre Valley Hospital	Larimer	15	3,147	$959,000
Mount San Rafael Hospital	Las Animas	14	607	$177,000
Lincoln Community Hospital	Lincoln	12	78	$18,000
Banner Health-Sterling Regional MedCenter	Logan	19	599	$231,000
Community Hospital	Mesa	12	222	$56,000
St. Mary's Hospital and Medical Center	Mesa	29	1,593	$939,000
Family Health West	Mesa	19	11	$4,000
The Memorial Hospital-Craig	Moffat	14	413	$117,000

2014-15 Hospital Quality Incentive Payments				
Hospital	**County**	**Points Earned**	**Medicaid Adjusted Discharges**	**HQIP Payment**
Southwest Memorial Hospital	Montezuma	10	730	$148,000
Montrose Memorial Hospital	Montrose	17	616	$213,000
Banner Health-East Morgan County Hospital	Morgan	19	225	$89,000
Colorado Plains Medical Center	Morgan	19	916	$354,000
Arkansas Valley Regional Medical Center	Otero	27	1,040	$567,000
Melissa Memorial Hospital	Phillips	17	56	$20,000
Aspen Valley Hospital	Pitkin	25	156	$79,000
Prowers Medical Center	Prowers	24	880	$429,000
Centura Health-St. Mary Corwin Medical Center	Pueblo	31	3,079	$1,940,000
Parkview Medical Center	Pueblo	24	5,321	$2,595,000
Pioneers Hospital	Rio Blanco	6	87	$10,000
Rangely District Hospital	Rio Blanco	46	18	$17,000
Rio Grande Hospital	Rio Grande	20	241	$98,000
Yampa Valley Medical Center	Routt	27	431	$237,000
Sedgwick County Memorial Hospital	Sedgwick	14	104	$30,000
Centura Health-St. Anthony Summit	Summit	29	401	$236,000
Pikes Peak Regional Hospital	Teller	16	272	$88,000
Banner Health-North Colorado Medical Center	Weld	24	5,684	$2,773,000
Wray Community Hospital	Yuma	21	191	$82,000
Yuma District Hospital	Yuma	46	224	$210,000
Total				**$61,448,873**

Table 3

Reduce the Need to Shift Costs of Uncompensated Care to Other Payers

Commented [DN9]: This section needs to be revised.

The CHCAA reduces the need to shift uncompensated care costs to private payers by increasing reimbursement to hospitals for inpatient and outpatient care provided for Medicaid and CICP patients and by reducing the number of uninsured Coloradans. Since its inception in July 2009, the hospital provider fee has increased hospital reimbursement an average of more than $150 million per year and increased enrollment in Medicaid and CHP+ to over 300,000 persons as of September 2014.

The OAB authorized a Cost Shift Data Work Group to determine what data will be collected by hospitals to fulfill the legislative requirement to report the difference between costs and payments for Medicare, Medicaid, and private insurance.

As recommended by the Cost Shift Data Work Group, cost and payment data is reported on a per patient basis for four payer groups: Medicare, Medicaid, private sector insurance, and CICP/Self Pay/Other. The information is calculated on a calendar year (CY) basis using data from the CHA DATABANK and survey data collected by CHA. CICP is shown as a separate item and is calculated on a state fiscal year basis using the Department's CICP Annual Report. An analysis of Bad Debt and Charity care is also included.

The information that follows shows calculations for CYs 2009 through 2013 and SFYs 2008-09 through 2012-13[2]. The CHCAA was implemented following federal approval in April 2010. The CY 2009 data shows cost to payment ratios prior to the implementation of the CHCAA, while changes due to the CHCAA are captured with data from CY 2010 and years that follow.

Because the information includes calculations through 2013 only, the impact of the January 2014 expansion of Medicaid coverage and implementation of the Connect for Health Colorado Marketplace pursuant to the Affordable Care Act (ACA) is not known at this time and is not reflected in this report.

[2] Cost shift data for per patient calculations for CY 2010-11 and SFY 2010-11 in this annual report have been corrected and differ from the data reflected in the previous annual report.

Cost Shift Data: Payment less Cost per Patient by Payer Group

The table and graph below display the differences between total payments and total costs on a per patient basis for Medicare, Medicaid, private sector insurance, and CICP/Self Pay/Other payer groups. Negative values indicate that costs exceed payments, while positive values indicate that payments exceed costs. This is the essence of cost shift as publicly funded care (Medicare and Medicaid) and uninsured care (CICP/Self Pay/Other) are paid under cost while private payers pay more to cover those costs.

The data in Table 4 show that the undercompensation for the Medicaid and CICP/Self Pay/Other payer groups has reduced sharply following the implementation of the CHCAA in July 2009. On a per patient basis, the payment below cost for hospital care has improved by more than $1,300 for Medicaid and more than $2,000 for CICP/Self Pay/Other when comparing CY 2009 to CY 2013 data.

Payment Less Cost per Patient by Payer Group

	CY 2009	CY 2010	CY 2011	CY 2012	CY 2013
Medicare	($3,039)	($3,941)	($3,762)	($3,886)	($5,319)[3]
Medicaid	($3,799)	($2,529)	($2,168)	($2,465)	($2,419)
Insurance	$7,271	$7,045	$7,598	$7,746	$7,717
CICP/Self Pay/ Other	($4,106)	($3,892)	($4,070)	($4,013)	($2,070)
Overall	$898	$622	$881	$903	$746

Table 4

[3] The recent decrease in the Medicare payer group reflects Medicare hospital payment reductions resulting from various federal laws including the ACA, the Budget Control Act of 2011, and the Bipartisan Budget Act of 2013.

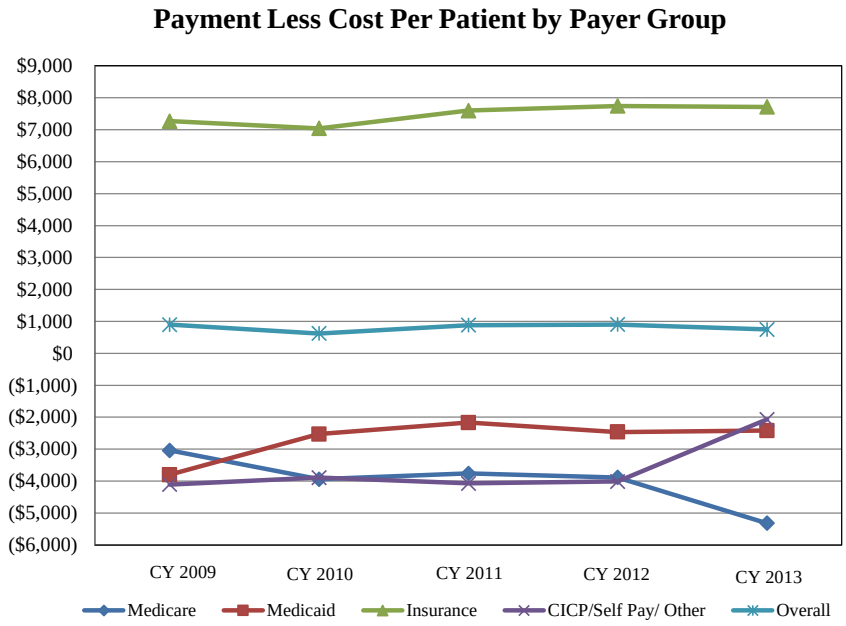

Figure 1

Cost Shift Data: Payment to Cost Ratio

Another way to view the impact of cost shifting is through the ratio of total payments to total costs for Medicare, Medicaid, private sector insurance, and CICP/Self Pay/Other payer groups. Ratios below 1 mean that costs exceed payments, which is the case for Medicare, Medicaid, and the CICP/Self Pay/Other payer groups. Values greater than 1 mean that payments exceed costs, as is the case for the private sector insurance group.

As shown below, in CY 2009, prior to the implementation of the CHCAA, Medicaid reimbursement to Colorado hospitals was approximately 61% of costs. The latest data from CY 2013 indicates that Medicaid reimbursement to hospitals has improved to approximately 80% of cost.

Payment to Cost Ratio by Payer Group

	CY 2009	CY 2010	CY 2011	CY 2012	CY 2013
Medicare	0.79	0.74	0.75	0.74	0.66[4]
Medicaid	0.61	0.75	0.79	0.79	0.80
Insurance	1.64	1.58	1.61	1.54	1.52
CICP/Self Pay/ Other	0.55	0.62	0.63	0.67	0.84
Overall	1.08	1.05	1.07	1.07	1.05

Table 5

[4] The recent decrease in the Medicare payer group reflects Medicare hospital payment reductions resulting from various federal laws including the ACA, the Budget Control Act of 2011, and the Bipartisan Budget Act of 2013.

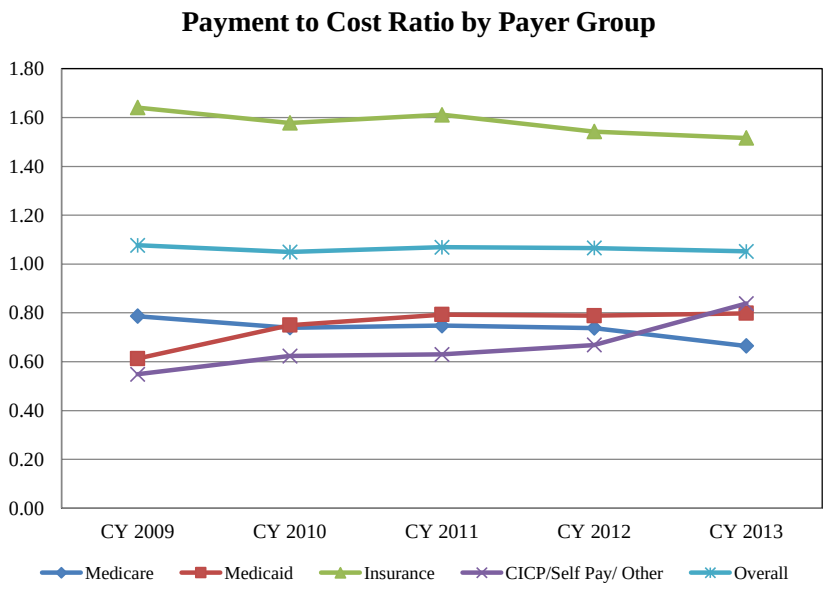
Payment to Cost Ratio by Payer Group
1.80
1.60
1.40
1.20
1.00
0.80
0.60
0.40
0.20
0.00
CY 2009
CY 2010
CY 2011
CY 2012
CY 2013
Medicare
Medicaid
Insurance
CICP/Self Pay/ Other
Overall

Figure 2

Cost Shift Data: Payment less Cost per Patient for CICP

Commented [DN10]: Per the OAB's comments last year, this section will be removed

The table and graph below display the difference between total payments and total costs on a per patient basis for CICP separately. The source of data for CICP is the Department's CICP Annual Report, which reports CICP costs and payments on a state fiscal year basis. As indicated before, negative values indicate that costs exceed payments, which is the case for CICP where hospitals are undercompensated for care provided to these clients.

The data show that following the implementation of the CHCAA in 2009, when CICP reimbursement rates for hospitals increased by at least $115 million annually, the amount of undercompensation of CICP costs decreased by approximately 35%. CICP funding has remained at the new levels following the implementation of the CHCAA.

Payment Less Cost Per Patient - CICP

	SFY 2008-09	SFY 2009-10	SFY 2010-11	SFY 2011-12	SFY 2012-13
CICP	($4,339)	($2,798)	($3,077)	($3,262)	($3,078)

Table 6

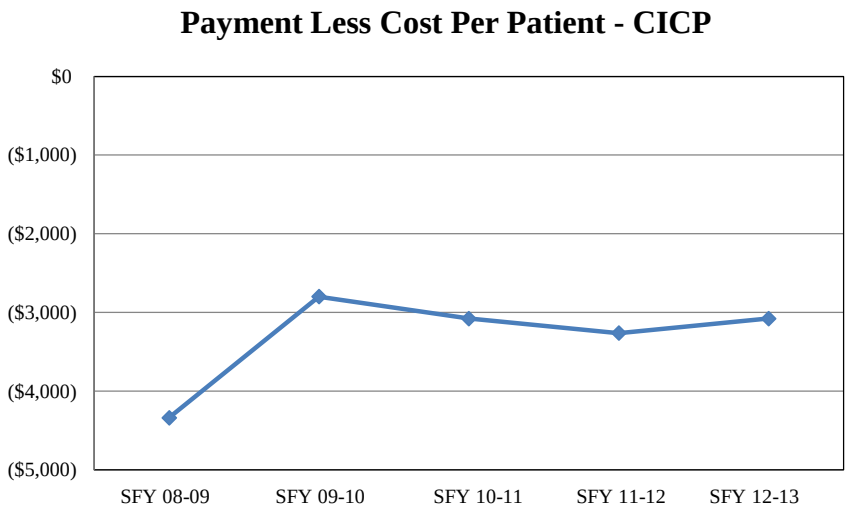

Figure 3

Cost Shift Data: Bad Debt and Charity Care

Total Bad Debt and Charity Care is collected in aggregate from the CHA DATABANK. Bad Debt and Charity Care distributions are calculated using weighted percentages as reported by providers on a survey conducted by the CHA.

Bad Debt was lower in each year than it was in CY 2009 until the latest data in CY 2013, where it rose by 28% compared to the prior year. More data information is needed before the Department can determine if this is the beginning of a trend for increasing Bad Debt or if this is an anomaly. Charity Care has increased an average of 3.5% each year, and the combined Bad Debt and Charity Care figure is nearly 14% higher in CY 2013 compared to CY 2009.

Bad Debt and Charity Care

	CY 2009	CY 2010	CY 2011	CY 2012	CY 2013
Bad Debt	$843,859,090	$776,483,052	$772,048,150	$743,972,504	$951,605,019
Charity Care	$1,450,212,300	$1,468,955,274	$1,565,544,819	$1,678,545,772	$1,657,809,286
Total	$2,294,071,390	$2,245,438,326	$2,337,592,969	$2,422,518,276	$2,609,414,305

Table 7

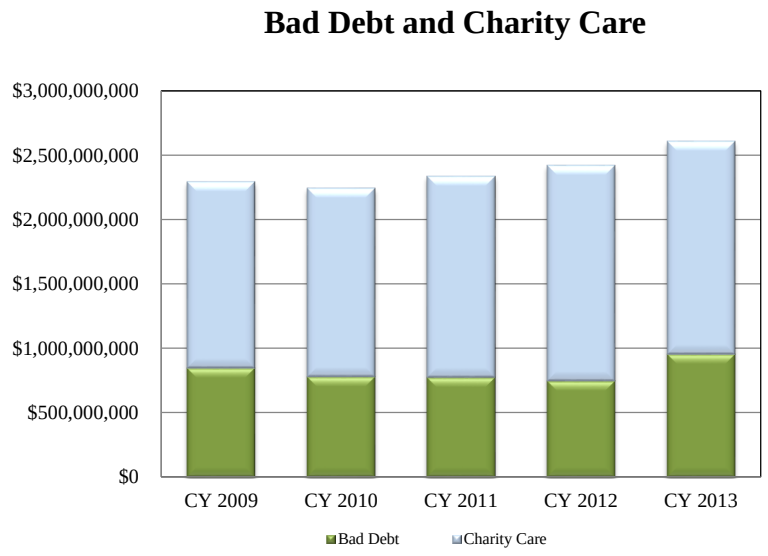

Figure 4

Department of Health Care Policy and Financing Expenditures

Commented [DN11]: This has been updated with SFY 2014-15 figures

As funding is appropriated on a state fiscal year basis, expenditures in this section are reported on a state fiscal year (SFY) basis. In SFY 2014-15 the Department collected $529 million in fees from hospitals, which, with federal matching funds, funded health coverage expansions, payments to hospitals, and the Department's administrative expenses. The following table outlines the Hospital Provider Fee expenditures in SFY 2014-15.

SFY 2014-15 Hospital Provider Fee Expenditures (Total Funds)[5]	
Supplemental Hospital Payments	$897,431,000
Department Administration	$38,289,000
Expansion Populations	$1,452,500,000
25.5-4-402.3 (4)(b)(VII) – Offset revenue loss	$15,700,000
Total Expenditures	**$2,403,899,000**

Table 8

Funding in SFY 2014-15 was appropriated for CHCAA administrative expenses through the normal budget process. For SFY 2014-15, the Department had approximately 65.1 regular full-time equivalent (FTE) positions for the administration of the CHCAA. The expenditures reflected in the following table are funded entirely by hospital provider fees and federal funds. These are new expenditures and do not supplant existing Department administrative funds. Approximately 1.59% of total CHCAA expenditures were for the Department's administrative expenses of administering the CHCAA, while about 0.21% of total CHCAA expenditures were for the personal services costs of the FTE administering the program.

SFY 2014-15 Administrative Expenditures	
(1) Executive Director's Office; (A) General Administration, Personal Services	$5,133,264
(1) Executive Director's Office; (A) General Administration, Legal Services	$255,480
(1) Executive Director's Office; (A) General Administration, Administrative Law Judge Services	$83,992
(1) Executive Director's Office; (A) General Administration: Operating Expenses	$64,380
(1) Executive Director's Office; (A) General Administration: Payments to OIT	$9,472
(1) Executive Director's Office; (A) General Administration: CORE Operations	$960,912
(1) Executive Director's Office; (A) General Administration: Leased Space	$249,848
(1) Executive Director's Office; (A) General Administration: General Professional Services and Special Projects	$725,536
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, MMIS System	$7,396,809
(1) Executive Director's Office; (C) Information Technology Contracts and Projects, Centralized Eligibility Vendor Contract Project	$6,845,253

[5] Figures in this table are reported on a state fiscal year basis (July 1 through June 30) and will not match other figures in this report, which are reported on an October 1 through September 30 basis.

SFY 2014-15 Administrative Expenditures	
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Medical Identification Cards	$117,476
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Contracts for Special Eligibility Determinations	$4,570,622
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Hospital Provider Fee County Administration	$4,277,662
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Customer Outreach	$673,240
(1) Executive Director's Office; (D) Eligibility Determinations and Client Services, Medical Assistance Sites	$78,000
(1) Executive Director's Office; (E) Utilization and Quality Review Contracts, Professional Services Contracts	$989,421
(1) Executive Director's Office; (F) Provider Audits and Services, Professional Audit Contracts	$188,400
(1) Executive Director's Office; (H) Indirect Cost Recoveries, Indirect Cost Assessment	$238,244
Total Executive Director's Office Expenditures	**$32,858,011**
(4) Indigent Care Program; Children's Basic Health Plan Administration	$9,360
(7) Department of Human Services Medicaid-Funded Programs; (B) Office of Information Technology, Colorado Benefits Management System, HCPF Only	$5,421,586
Total	**$38,288,957**

Table 9

Hospital Provider Fee – Fee and Payment Methodologies

On March 31, 2010, the CMS first approved the Department's request to waive the "uniform" and "broad-based" requirements for a provider fee under 42 CFR § 433.68(e)(2) and approved the Department's State Plan Amendments for supplemental Medicaid and DSH payments. The hospital provider fee, State Plan Amendments, and UPL methodologies were first approved by the CMS on March 31, 2010 and retroactively effective July 1, 2009.

The fee and payment calculations are dynamic where fee and payment methodologies are calculated, reviewed, and approved on an annual basis. Data to calculate fees and payments are compiled annually. Changes to fee or payment methodologies may be needed to respond to changing Medicaid and uninsured client utilization patterns, Medicaid caseload, strategic goals of the Department, the health care market, or other factors.

Hospital provider fees are calculated on inpatient and outpatient hospital services. Inpatient hospital fees are assessed on patient days; outpatient hospital fees are assessed on outpatient charges. Free-standing psychiatric, long term care, and rehabilitation hospitals are exempt from paying the fees, while high-volume Medicaid and CICP hospitals and small rural hospitals pay reduced fees. The OAB continued its recommendation to exempt free-standing psychiatric hospitals, long term care hospitals, and rehabilitation hospitals from fees because the goals of the CHCAA include reducing uncompensated costs and increasing access for Medicaid and uninsured clients. Free-standing psychiatric hospitals meet the definition of Institutions for Mental Diseases (IMDs) under 42 CFR §435.1010. Federal Financial Participation (FFP) is not available for Medicaid clients from age 22 through age 64 who are patients in an IMD, as noted under 42 CFR §435.1009(a)(2). Long term care and rehabilitation hospitals do not pay fees but do receive an increased Medicaid inpatient hospital payment if they choose to participate in Medicaid to assure access for Medicaid clients.

Hospital payments financed with provider fees are made for services provided to Medicaid and CICP patients through supplemental payments that are paid directly to hospitals, outside the Department's Medicaid Management Information System (MMIS). The purpose of these inpatient and outpatient Medicaid payments, uncompensated care and DSH payments, and quality incentive payments is to reduce hospitals' uncompensated care costs for providing care for Medicaid clients and the uninsured and to incentivize quality care.

Commented [DN12]: updated

Fees are collected and payments are made on a monthly basis, and nearly all hospitals have authorized electronic fee and payment processing. The 2014-15 fee and payment amounts by type are outlined in the following table. See Appendix A for more information about fee and payment methodologies.

2014-15 Hospital Provider Fees and Payments	
Inpatient Fee	$364,306,000
Outpatient fee	$324,142,000
Total Hospital Provider Fees	**$688,448,000**
Inpatient Hospital Reimbursement	$606,802,000
Outpatient Hospital Reimbursement	$207,647,000
Uncompensated Care Payment	$115,400,000
Disproportionate Share Hospital Payment	$194,902,000
Hospital Quality Incentive Payment	$61,449,000
Total Supplemental Hospital Payments	**$1,186,200,000**

Table 10

APPENDIX A: 2014-15 Hospital Provider Fee Overview

This overview describes the fee assessment and payment methodologies for October 2014 through September 2015 under the CHCAA. While no hospital is eligible for all payments, all methodologies are described.

Provider Fees

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Inpatient Hospital Fee and Outpatient Fee

Total Fees collected were $688,448,000. Inpatient fees comprised 53% of total fees, while outpatient fees comprised 47%.

Inpatient fee is charged on a facility's managed care days and non-managed care days. fee charged on managed care days are discounted by 77.63% compared to the rate assessed on non-managed care days. Managed care days are Medicaid HMO, Medicare HMO, and any commercial PPO or HMO days. Non-Managed Care Days are all other days (i.e., fee for service, normal DRG or indemnity plan days).

Outpatient fee is assessed as a percentage of total outpatient charges.

Hospitals Exempt from Inpatient and Outpatient Hospital Fees

State Licensed Psychiatric Hospitals

Medicare Certified Long Term Care (LTC) Hospitals

State Licensed and Medicare Certified Rehabilitation Hospitals

Hospitals Assessed Discounted Fees

High Volume Medicaid and CICP providers are those providers with at least 35,000 Medicaid days per year that provide over 30% of their total days to Medicaid and CICP clients. The inpatient fee calculation for High Volume Medicaid and CICP providers is discounted by 47.79%. The outpatient fee for High Volume Medicaid and CICP providers is discounted by 0.84%.

Essential Access providers are those providers that are Critical Access Hospitals and other rural hospitals with 25 or fewer beds.

The inpatient fee calculation for Essential Access providers is discounted by 60%.

Supplemental Hospital Payments

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Inpatient Hospital Payment

For qualified hospitals, this payment equals Medicaid estimated discharges, multiplied by average Medicaid case mix, multiplied by the Medicaid base rate, multiplied by percentage adjustment factors may vary by hospital. The percentage adjustment factor for each hospital is published annually in the Colorado Medicaid Provider Bulletin.

State Licensed Psychiatric Hospitals are not qualified for this payment.

Outpatient Hospital Payment

For qualified hospitals, this payment equals Medicaid outpatient billed costs, adjusted for utilization, and inflation, multiplied by a percentage adjustment factor. Percentage adjustment factors may vary by hospital. The percentage adjustment factor for each hospital is published annually in the Colorado Medicaid Provider Bulletin.

State Licensed Psychiatric Hospitals are not qualified for this payment.

Uncompensated Care Payment

The Uncompensated Care Payment for qualified hospitals with 25 or fewer beds equals the hospital's percent of beds compared to total beds for all qualified hospitals with 25 or fewer beds multiplied by $33,500,000. The Uncompensated Care Payment for qualified hospitals with greater than 25 beds is the hospitals' percent of uninsured costs compared to total uninsured costs for all qualified hospitals with greater than 25 beds multiplied by $81,980,176.

Psychiatric hospitals, LTC hospitals, and rehabilitation hospitals do not qualify for this payment.

Disproportionate Share Hospital Payment

The DSH payment equals the percent of uninsured costs to total uninsured costs of all qualified hospitals, multiplied by the DSH allotment in total computable of $196,484,793. No hospital will receive a DSH Payment greater than its estimated DSH limit.

To qualify for the DSH Payment a Colorado hospital shall meet either of the following criteria:

Is a Colorado Indigent Care Program provider, and has at least two Obstetricians or is Obstetrician exempt pursuant to Section 1923(d)(2)(A) of the Social Security Act; or

Has a Medicaid Inpatient Utilization Rate equal to or greater than the mean plus one standard deviation of all Medicaid Inpatient Utilization Rates for Colorado hospitals, and has at least two Obstetricians or is Obstetrician exempt pursuant to Section 1923(d)(2)(A) of the Social Security Act.

State Licensed Psychiatric Hospitals are not qualified for this payment.

APPENDIX B: October 2014 - September 2015 Hospital Provider Fees and Payments by Hospital

Commented [DN15]: has been updated

Fee-Exempt Hospitals – Free-Standing Psychiatric, Long Term Care, and Rehabilitation Hospitals					
Hospital Name	**County**	**Fees**	**Payments**	**Appx CICP Payments pre-CHCAA**	**Net Reimbursement Increase**
Haven Behavioral Health at North Denver	Adams	$0	$0	$0	$0
HealthOne Spalding Rehabilitation Hospital	Adams	$0	$126,580	$0	$126,580
Vibra Long Term Acute Care Hospital	Adams	$0	$30,503	$0	$30,503
Craig Hospital	Arapahoe	$0	$538,245	$0	$538,245
HealthSouth Rehabilitation Hospital - Denver	Arapahoe	$0	$114,255	$0	$114,255
Kindred Hospital Aurora	Arapahoe	$0	$2,473	$0	$2,473
Centennial Peaks Hospital	Boulder	$0	$0	$0	$0
Colorado Acute Long Term Hospital	Denver	$0	$194,771	$0	$194,771
Colorado Mental Health Institute-Ft Logan	Denver	$0	$0	$0	$0
Eating Recovery Center	Denver	$0	$0	$0	$0
Kindred Hospital	Denver	$0	$14,682	$0	$14,682
Select Specialty Hospital - Denver	Denver	$0	$888	$0	$888
Highlands Behavioral Health System	Douglas	$0	$0	$0	$0
Cedar Springs Behavior Health System	El Paso	$0	$0	$0	$0
HealthSouth Rehabilitation Hospital - Colorado Springs	El Paso	$0	$167,250	$0	$167,250
Select Long Term Care Hospital	El Paso	$0	$2,056	$0	$2,056
Northern Colorado Long Term Acute Care Hospital	Larimer	$0	$1,274	$0	$1,274
Colorado West Psychiatric Hospital Inc	Mesa	$0	$0	$0	$0
Colorado Mental Health Institute-Pueblo	Pueblo	$0	$0	$0	$0
Haven Behavioral Senior Care at St. Mary-Corwin	Pueblo	$0	$0	$0	$0
Peak View Behavioral Health	Pueblo	$0	$0	$0	$0
Northern Colorado Rehabilitation Hospital	Weld	$0	$92,910	$0	$92,910
Total		**$0**	**$1,285,888**	**$0**	**$1,285,888**

Fee-Paying Hospitals – General, Acute Care Hospitals					
Hospital Name	**County**	**Fees**	**Payments**	**Appx CICP Payments pre-CHCAA**	**Net Reimbursement Increase**
Centura Health - Saint Anthony North Hospital	Adams	$10,428,872	$19,516,493	$0	$9,087,621
Children's Hospital Colorado	Adams	$21,866,229	$59,530,549	$2,854,794	$34,809,526
HealthOne North Suburban Medical Center	Adams	$13,925,867	$24,029,354	$0	$10,103,488
Platte Valley Medical Center	Adams	$4,917,191	$12,700,107	$1,499,298	$6,283,618
University of Colorado Hospital	Adams	$44,140,802	$83,195,449	$36,264,181	$2,790,466
San Luis Valley Regional Medical Center	Alamosa	$3,033,118	$11,357,199	$962,324	$7,361,757
Centura Health - Littleton Adventist Hospital	Arapahoe	$17,655,464	$12,130,977	$0	-$5,524,488
HealthOne Medical Center of Aurora	Arapahoe	$29,469,809	$32,729,311	$0	$3,259,502
HealthOne Swedish Medical Center	Arapahoe	$32,424,638	$32,237,280	$0	-$187,358
Pagosa Mountain Hospital	Archuleta	$308,651	$1,345,735	$0	$1,037,083
Southeast Colorado Hospital	Baca	$199,123	$1,731,131	$34,179	$1,497,829
Boulder Community Hospital	Boulder	$17,664,843	$17,240,779	$1,063,630	-$1,487,694
Centura Health - Avista Adventist Hospital	Boulder	$6,400,673	$13,041,009	$0	$6,640,335
Exempla Good Samaritan Medical Center	Boulder	$16,109,388	$8,936,250	$0	-$7,173,138
Longmont United Hospital	Boulder	$10,277,309	$18,694,274	$1,633,746	$6,783,219
Heart of the Rockies Regional Medical Center	Chaffee	$1,245,177	$4,289,063	$247,500	$2,796,386
Keefe Memorial Hospital	Cheyenne	$81,750	$1,477,121	$0	$1,395,371
Conejos County Hospital	Conejos	$199,633	$2,086,708	$99,884	$1,787,191
Delta County Memorial Hospital	Delta	$3,211,571	$4,865,490	$912,623	$741,296
Centura Health - Porter Adventist Hospital	Denver	$17,358,722	$15,325,787	$0	-$2,032,935
Centura Health - Saint Anthony Central Hospital	Denver	$20,813,008	$24,061,688	$0	$3,248,680
Denver Health Medical Center	Denver	$24,226,398	$134,332,819	$64,455,024	$45,651,397
Exempla Saint Joseph Hospital	Denver	$24,059,083	$32,026,116	$0	$7,967,032
HealthOne Presbyterian/St. Luke's Medical Center	Denver	$25,626,268	$41,387,815	$0	$15,761,547
HealthOne Rose Medical Center	Denver	$21,328,037	$24,438,693	$0	$3,110,657
National Jewish Health	Denver	$2,714,796	$10,992,672	$1,682,780	$6,595,096
Castle Rock Adventist Hospital	Douglas	$4,334,207	$2,167,402	$0	-$2,166,805

Fee-Paying Hospitals – General, Acute Care Hospitals					
Hospital Name	**County**	**Fees**	**Payments**	**Appx CICP Payments pre-CHCAA**	**Net Reimbursement Increase**
Centura Health - Parker Adventist Hospital	Douglas	$11,235,748	$11,491,997	$0	$256,249
HealthOne Sky Ridge Medical Center	Douglas	$18,615,564	$8,685,694	$0	-$9,929,870
Vail Valley Medical Center	Eagle	$4,282,959	$7,171,861	$0	$2,888,902
Centura Health - Penrose -St. Francis Health Services	El Paso	$35,731,616	$38,537,291	$2,195,836	$609,840
Memorial Hospital	El Paso	$36,200,137	$61,466,998	$16,142,511	$9,124,350
Centura Health - St. Thomas More Hospital	Fremont	$3,218,090	$8,147,626	$779,972	$4,149,563
Grand River Medical Center	Garfield	$863,772	$4,213,479	$190,609	$3,159,098
Valley View Hospital	Garfield	$5,401,842	$17,744,644	$444,750	$11,898,052
Kremmling Memorial Hospital	Grand	$362,532	$2,231,869	$117,393	$1,751,944
Gunnison Valley Hospital	Gunnison	$577,277	$2,634,484	$42,048	$2,015,159
Spanish Peaks Regional Health Center	Huerfano	$367,904	$2,873,271	$135,879	$2,369,488
Centura Health - Ortho Colorado	Jefferson	$1,589,360	$0	$0	-$1,589,360
Exempla Lutheran Medical Center	Jefferson	$29,514,347	$35,348,126	$0	$5,833,779
Weisbrod Memorial County Hospital	Kiowa	$54,335	$616,872	$0	$562,537
Kit Carson County Memorial Hospital	Kit Carson	$363,885	$2,249,456	$0	$1,885,571
Animas Surgical Hospital	La Plata	$823,410	$1,897,849	$0	$1,074,439
Mercy Medical Center	La Plata	$6,290,868	$14,428,119	$534,968	$7,602,283
St. Vincent General Hospital District	Lake	$206,756	$2,024,493	$118,153	$1,699,584
Estes Park Medical Center	Larimer	$812,811	$1,845,983	$435,234	$597,937
McKee Medical Center	Larimer	$7,296,628	$11,463,344	$2,131,572	$2,035,144
Medical Center of the Rockies	Larimer	$12,928,455	$19,519,694	$1,584,786	$5,006,453
Poudre Valley Hospital	Larimer	$22,569,004	$40,760,824	$5,935,254	$12,256,567
Mount San Rafael Hospital	Las Animas	$977,885	$4,794,690	$134,622	$3,682,183
Lincoln Community Hospital and Nursing Home	Lincoln	$253,464	$1,259,483	$0	$1,006,019
Sterling Regional MedCenter	Logan	$1,470,381	$5,848,241	$794,952	$3,582,908
Community Hospital	Mesa	$3,494,521	$5,085,317	$170,542	$1,420,254
Family Health West Hospital	Mesa	$475,243	$1,604,038	$0	$1,128,795

Fee-Paying Hospitals – General, Acute Care Hospitals					
Hospital Name	**County**	**Fees**	**Payments**	**Appx CICP Payments pre-CHCAA**	**Net Reimbursement Increase**
St. Mary's Hospital and Medical Center	Mesa	$21,468,852	$33,037,834	$1,747,192	$9,821,790
The Memorial Hosptial	Moffat	$910,008	$4,203,036	$167,785	$3,125,244
Southwest Memorial Hospital	Montezuma	$1,374,200	$5,798,973	$383,352	$4,041,421
Montrose Memorial Hospital	Montrose	$4,461,089	$8,812,051	$1,054,452	$3,296,511
Colorado Plains Medical Center	Morgan	$3,056,575	$6,487,770	$162,836	$3,268,359
East Morgan County Hospital	Morgan	$687,160	$3,079,170	$175,025	$2,216,985
Arkansas Valley Regional Medical Center	Otero	$2,782,166	$7,629,372	$1,374,965	$3,472,241
Haxtun Hospital	Phillips	$78,850	$1,493,391	$0	$1,414,541
Melissa Memorial Hospital	Phillips	$180,476	$1,141,079	$40,279	$920,324
Aspen Valley Hospital	Pitkin	$1,284,388	$4,009,056	$490,839	$2,233,830
Prowers Medical Center	Prowers	$773,092	$5,764,229	$407,322	$4,583,815
Centura Health - St. Mary-Corwin Medical Center	Pueblo	$14,654,045	$31,107,307	$2,978,448	$13,474,814
Parkview Medical Center	Pueblo	$27,856,873	$47,203,536	$3,603,807	$15,742,856
Pioneers Hospital	Rio Blanco	$174,460	$1,174,566	$0	$1,000,106
Rangely District Hospital	Rio Blanco	$95,855	$1,469,351	$0	$1,373,496
Rio Grande Hospital	Rio Grande	$407,061	$1,959,364	$51,020	$1,501,283
Yampa Valley Medical Center	Routt	$2,136,958	$4,448,258	$168,950	$2,142,350
Sedgwick County Memorial Hospital	Sedgwick	$187,524	$1,202,600	$27,239	$987,837
Centura Health - Saint Anthony Summit Hospital	Summit	$2,050,209	$3,330,398	$0	$1,280,189
Pikes Peak Regional Hospital	Teller	$647,074	$2,587,892	$55,614	$1,885,204
North Colorado Medical Center	Weld	$22,379,011	$45,136,822	$6,182,516	$16,575,295
Wray Community District Hospital	Yuma	$347,962	$1,953,302	$107,405	$1,497,935
Yuma District Hospital	Yuma	$454,166	$2,071,911	$98,017	$1,519,728
Total		**$688,447,475**	**$1,184,914,284**	**$162,876,107**	**$333,590,701**
Total All Hospitals[6]		**$688,447,475**	**$1,186,200,172**	**$162,876,107**	**$334,876,589**

[6] Figures may not sum to totals due to rounding

APPENDIX C: Hospital Provider Fee Oversight and Advisory Board Members

Commented [DN16]: has been updated

As required in the CHCAA, the OAB is comprised of the following:

- Five hospital members including at least one rural hospital representative and one safety-net hospital representative;
- One statewide hospital organization member;
- One health insurance organization or carrier member;
- One health care industry member who does not represent a hospital or health insurance carrier;
- One health care consumer who does not represent employees of a hospital, health insurance carrier, or other health care industry entity;
- One representative of persons with disabilities who does not represent employees of a hospital, health insurance carrier, or other health care industry entity;
- One business representative who purchases health insurance for employees; and
- Two Department of Health Care Policy and Financing members.

Current Board Members by Term Expiration Date

For terms expiring May 15, 2016:

Peg Burnette of Denver, representing a hospital
Dan Enderson of Castle Rock, representing a hospital
George O'Brien of Pueblo, representing persons with disabilities

For terms expiring May 15, 2017:

Kathryn Ashenfelter of Denver, representing a hospital
Dr. Jeremiah Bartley of Brighton, representing the health care industry
Ann King of Denver, representing a statewide hospital organization
David Livingston of Denver, representing a business, to serve as Chair
Mirna Ramirez-Castro of Thornton, representing a consumer of health care
Dan Rieber of Castle Rock, representing a safety-net hospital
Christopher Underwood of Evergreen, representing the Department

For terms expiring May 15, 2019:

John Gardner of Yuma, representing a rural hospital
William Heller of Denver, representing the Department
Thomas Rennell of Castle Rock, representing a health insurance organization

APPENDIX D: Federal Requirements Overview

Commented [DN17]: no changes

Provider fees are a funding source eligible for federal matching funds when used to reimburse Medicaid covered services as allowed under 42 CFR 433.68(d). Through this regulation, revenue collected from provider fees may serve as state share of Medicaid expenditures to draw a federal match. In general, to be eligible for FFP, provider fees must:

- Be imposed on a permissible class of health care services, including, but not limited to, inpatient hospital services and outpatient hospital services.
- Be broad-based, such that the fee is imposed on all providers within a class.
- Be imposed uniformly throughout a jurisdiction, such that all providers within a class are assessed at the same rate.
- Avoid hold harmless arrangements where the non-Medicaid payments reimbursement amount is positively correlated to the assessment paid by the provider, either directly or indirectly, or where the Medicaid payments vary based only on the tax amount. In other words, there will be winners and losers, where some providers will receive proportionately less in reimbursement compared to their assessed amount.

CMS may grant waivers of the broad-based and uniformity provisions if the net impact of the fee is generally redistributive, as demonstrated via statistical tests described in regulation.

Health care related fees may be based on a licensing fee on a class of health care services, on a fee per bed, on revenues or other general statistic with respect to a class of services. Per federal law and regulations, the amount assessed on providers of a class of services may not exceed 6% of the net patient revenue for that class of services. (Congress temporarily reduced the cap to 5.5% from January 1, 2008 through September 30, 2011.)

Fees can be collected and payments can be made only after approval is obtained from CMS and only to the extent FFP is available under the Upper Payment Limit (UPL) for inpatient and outpatient hospital services after Medicaid reimbursement. Distribution of funds under a provider fee model may be made through supplemental Disproportionate Share Hospital (DSH) payments, increased Medicaid rates, supplemental Medicaid payments, a combination of methods, or other methodologies approved by CMS.